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Health insurance reform in the United States: old lessons on a renewed debate

Key words: American health reform, American health care system, health system financing

Introduction

The American health care system is characterized as the most expensive health care system in the developed world[1]. According to the most recent health care report by Organisation for Economic Co-operation and Development (OECD), the United States spent 16% of its GDP on health in 2007 (as compared to the OECD average of 8.9%). In 2007, the United States spent $7 290 per person on health care (compared to $1 035 per person in Poland), which is almost two-and-a-half times higher than the OECD average ($2 984 per person)[2]. Yet, despite the amount of money Americans spend on health, the health care system still suffers from inefficiencies in delivering preventive and primary care and palliative and treatment services[3].

Unlike most developed countries, the United States lacks a mandate for universal health coverage. The United States does not have a national health insurance program and the health care system is largely based on a fee-for-service system established in the late 19th Century. This has led to a privately run health insurance system, based on the free market and a relatively weak regulatory framework. Yet, the private market has been unable to ensure universal coverage, with 15.4% of the U.S. population (46.3 million Americans) without health insurance in 2008[4]. Additionally, costs of health insurance coverage have continued to rise. Despite efforts by the private insurance companies to curtail costs (i.e. move to managed-care style insurance), health insurance premiums for families rose 131% between 1999 and 2009[5].

The election of Barack Obama suggested a shift, even if even temporary, in the American political posture. The costs of health care and the rising number of uninsured Americans without access to proper care was one of the key issues of the Obama election campaign. The political momentum of President Obama's victory and the fact that both chambers of the Congress are controlled by the Democrats are crucial driving factors behind the reforms. Yet, history has proven that even pragmatic change in the American health system is extremely difficult, and any sort of movement towards a national health insurance program is portrayed as a move away from the core values of American society, despite the fact that reformers have been proposing such a program since the early 20th Century.

This article is written primarily for the Polish and the European audience. The aim of the article is to provide a historical perspective on the American health care system and reform, discuss the current state of the system, and analyze the potential effects of proposed reforms in light of this historical framework. The historical section will describe the evolution of the modern American insurance system and illustrate how and why the strength of the opposition for government health care coverage defeated reform efforts in the past.

[1] Igelhart J., *The American Health Care System: Expenditures*. „The New England Journal of Medicine" 1999; 340(1): 70–6.

[2] Organisation for Economic Co-operation and Development (2009), *Health at a Glance 2009*. http://www.oecd.org/document/14/0,3343, en_2649_34631_16502667_1_1_1_1,00.html. pp. 80–89.

[3] Parson M., *Disparities in health expenditure across OECD countries: Why does the United States spend so much more than other countries?* Written Statement to Senate Special Committee on Aging – 30th September 2009. http://www.oecdwash.org/PDFILES/Pearson_Testimony_30Sept2009.pdf.

[4] U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2008.* Washington DC 2009. http://www.census.gov/prod/2009pubs/p60-236.pdf.

[5] The Kaiser Family Foundation & Health Research and Education Trust. 2009 Annual Survey: Employer Health Benefits. http://ehbs.kff.org/pdf/2009/7936.pdf.

At various points in history, the majority of efforts for major reform or a national health insurance program in the United States met considerable resistance and failure. The periods immediately following failed reform efforts are characterized with a response from the private sector aiming to curtail the rising costs. These responses seemingly moved the American health care system farther into the free-market, complicating future efforts for reform. In 2009, as in years past, the cycle of health care reform has repeated: rising health care costs, a public call for reform, considerable opposition to reform, and proposals by the President and Congress on the table. The question that remains for 2010: Will this round of health reform finally clear a path to comprehensively alter the complex American health care system or will it once again succumb to the opposition, as it had at many times in the past? If the former, it may truly be a first step to an ideological shift in American political values; if the latter, will the free-market once again step in to alter its model in an attempt to control escalating costs and meet the demand of the uninsured?

History of the American health care system and reform

Institutionalization and evolution of a system: voluntary and employer-based health insurance

The private insurance system in the United States evolved after a series of failed efforts by Democrats and reformists during the 1930s and 1940s to create a government sponsored health insurance program. By 1950, about 54.5 million Americans, roughly one-third of the population, had private health insurance[6]. The decision to exclude government regulated universal health coverage by the United States government, by default, privatized the obligation, in effect delegating this obligation to employers, individuals and insurance companies and institutionalized the employer-based voluntary health insurance system that exists today. The private sector emerged as the primary source of health insurance coverage for Americans and the health care system began shaping itself around it.

Initially, private health insurance plans emerged as a non-for-profit enterprise with prepaid employee plans for hospital coverage. This plan became known as "Blue Cross." Soon after, "Blue Shield" plans emerged to cover medical costs of physician visits by adopting the Blue Cross framework[7]. When the nonprofit Blue Cross and Blue Shield plans came into existence, most coverage was based on the individual rather than groups. It wasn't until after World War II, that employers began providing benefit packages, including the newly minted Blue Cross/Blue Shield-style health insurance, to entice workers[8]. At the same time, private insurance companies began to recognize the opportunity to make a profit and entered the health insurance market as well, in direct competition to nonprofit Blue Cross/Blue Shield plans. Employers began turning to some of the cheaper alternative plans to offer their employees. To accommodate all these changes, the government amended the tax code in 1954 to recognize employer contributions to its employee's health insurance plans as nontaxable. Between 1953 and 1958, the percentage of Americans covered by private health insurance plans increased from 63 percent to 75 percent, arguably as a result of this tax subsidy[9]. By the mid-1950s, private health insurance, for-profit or not-for-profit, became a fact of American life.

During this time, insurance companies also developed methods on establishing premiums and assessing risk of participants in the plans. The original Blue Cross/Blue Shield plans used a "community rating" system to assess the costs of the plan. The community rating system used the locality in which subscribers live as the risk pool to base the cost of the insurance. Under a community rating system all subscribers in the area pay the same premium regardless of their individual health status[10]. The new private insurance plans shifted to a different rating system. These plans began using an "experience rating" system to assess risk and assign costs of a health insurance premium. Experience ratings assess risk to the individual (or group of individuals) in the plan. For example, if the members of group are all young and healthy and rarely use health care services, this group's premiums will be less than those of an older group.

Medicare – a step towards national health insurance?

One major issue that the private sector could not seem to address, however, was the issue of an aging population and covering the health care costs of the retired persons. By 1960, it was clear that private health insurance was not working for the elderly. As a larger portion of the population was beginning to retire and as medical technologies and treatment methods improved, costs were also rising. Between 1950 and 1960, the cost for hospitalization rose about 6.7 percent a year. As a result, private health insurance companies raised their rates to match the increase in costs, making health insurance for the elderly very difficult to attain. By the mid-1960s, only about half of the elderly had health insurance, and those that did have health insurance had expensive policies

[6] Kresl H., & Malone N., *How We Got Here: a history of the American healthcare system with respect to organizational information flows*. University of Washington, Information School. March 1st, 2009.

[7] Consumer Union, *Blue Cross and Blue Shield A Historical Compilation*. http://www.consumersunion.org/conv/conversions_101/legal_context/doctrines_and_remedies/applying_the_charitable_trust_and_cy_pres_doctrines/Blue%20Cross%20History%20Compilation.pdf.

[8] Hermer L., *Private Health Insurance in the United States: A proposal for a more functional system*. „Houston Journal of Health Law & Policy" 2005; Vol. 6 (1).

[9] Thomasson M., *From Sickness to Health: The twentieth-century development of U.S. health insurance*. „Explorations in Economic History" 2005; 39: 233–253.

[10] Hermer L., *op. cit.*

that did not offer comprehensive coverage[11]. Moreover, from the perspective of the health insurance industry, the high costs of covering the elderly was not a profitable venture[12].

This situation, and the 1960 election of Senator John F. Kennedy to the American presidency, once again brought back the movement for a national health insurance program. However, the idea of a comprehensive national health insurance program, did not resurface in the debate. Rather, the debate focused on covering the high-costs of the elderly, most of whom could not afford private health insurance. This initiative became known as "Medicare". (It is important to note that many who designed the Medicare program of the 1960s expected it to be a first step toward universal national health insurance[13]). A few days after his inauguration, President Kennedy sent a special message to Congress on health, requesting they debate legislation to create a government-run health insurance system for the elderly.

The assassination of President Kennedy in 1963 had a profound effect on the success of Medicare. In his 1969 account of the history of the Medicare program, Peter Corning noted: "One of the many consequences of that tragedy was a surge of public support for the martyred President's legislative program. The new President, Lyndon B. Johnson, a renowned legislative leader, moved quickly to act upon these sentiments[14]." Public support for the Medicare program, in particular, was strong during this time. Polling from 1964 and 1965 showed broad support for the idea of Medicare. According to a January 1965 Gallup poll, 63% approved of the Medicare initiative and 28% disapproved[15].

Despite its popularity, Medicare did face strong opposition as had similar movements of the 1940s. The fight against government intervention in the health care sector was led by the American Medical Association. They employed a similar method of public relations as they did in the 1940s by reaching out directly to the public. One feature of the anti-Medicare campaign was called "Operation Coffee Cup", a recording featuring (then actor) Ronald Reagan. On the recording, Reagan, "as a private citizen", described Medicare as the imminent "imposition of statism and socialism" by the government on its people and that if Medicare passed, Americans "will awake to find we have socialism". The AMA sent the recording to physicians' wives to play for their friends and neighbors and urged citizens to write to their Congressmen to stop Medicare[16,17].

The opposition's efforts, however, failed. In 1965, Congress passed the Medicare program as well as a government health care program aimed at providing assistance for the poor, labeled "Medicaid". Unlike Medicare, which is a federally-administered program, Medicaid provides funding to states (who must match that funding amount) and requires the states to administer their own programs. The passage of Medicare and Medicaid in 1965 was a significant victory for reformers and has considerably altered the way the American government participates in the health care sector. These programs, particularly Medicare, remain widely popular today, and despite some efforts to reform them, there have been no efforts to repeal them.

HMOs and the rise of managed care

By 1970, about 205 million Americans were covered by private health insurance. Still, costs continued to rise. Between 1950 and 1970, national health expenditures increased 586% (from $12.7 billion to $74.4 billion), while the American gross national product (GNP) only rose 347% during the same time period[18]. The traditional response to the increase in medical costs was for the insurance companies to raise its premiums. However, as the system was employer-based, employers experienced difficulties in maintaining these costs for their employees. The costs were becoming too difficult to contain and a shift in how the delivery and payment system had to somehow accommodate these changes.

As health care costs continued to increase, those reformers who advocated for national health insurance coverage continued their fight, building off the success of Medicare. The most notable of the reformers was a young Senator from the State of Massachusetts, Edward (Ted) Kennedy – the brother of the late-President John Kennedy. In 1971, Senator Kennedy introduced legislation, aimed at building the foundation for a universal, national health insurance system that would dramatically change the American health care system. Kennedy's "Health Security Act" was a proposal for a universal single-payer plan with a budget for the national health program to be financed through income taxes[19]. Kennedy's program, modeled after the Medicare program, aimed to create a "single-payer system" where the federal government would be the purchaser of all health services.

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[11] Corning P., *The Evolution of Medicare: from idea to law.* As republished by the U.S. Social Security Administration. http://www.ssa.gov/history/corning.html.

[12] National Academy of Social Insurance. *Medicare and the American Social Contract*. Final Report of the Study Panel on Medicare's Larger Social Role 1999.

[13] See: R.M. Ball, *What Medicare's Architects had in Mind*. „Health Affairs" 1995.

[14] Corning P., *op. cit.*

[15] As stated in: Kohut A., *Would Americans Welcome Medicare if it Were Being Proposed in 2009?* New Research Center, 19 August 2009. http://pewresearch.org/pubs/1317/would-americans-welcome-medicare-if-proposed-in-2009.

[16] Altom L., & Churchill L., *Pay, Pride, and Public Purpose: Why America's Doctors Should Support Universal Healthcare*. „MedGenMed" 2007; 9(1): 40. Published online 2007 February 28. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1925024/

[17] *Ronald Reagan Speaks Out Against Socialized Medicine*: *Clips can be heard here*. http://www.youtube.com/watch?v=fRdLpem-AAs.

[18] Day J.G., *Managed Care and the Medical Profession: Old Issues and Old Tensions*. „Conn. Insurance Law Journal" 1996; Vol. 3 (1).

[19] Kaiser Family Foundation, *National Health Insurance – A Brief History of Reform Efforts in the U.S.*, 2009. http://www.kff.org/healthreform/upload/7871.pdf. March 2009.

Leading Republicans, who traditionally were against national health care legislation, came out in support of a form of national health care reform. In 1974, President Richard Nixon addressed Congress to voice his support for a national health reform strategy. Some saw this as a means to divert attention away from the growing "Watergate" scandal and a way to diminish support for Kennedy's more liberal reforms[20]. Nixon's proposal supported the regulation of the existing private insurance industry. Nixon articulated his vision for health reform in the 1973 National HMO Act, a program which was meant to promote competition and give rise to what is known as the Health Maintenance Organization (HMO). Although the medical community certainly did not approve of this program, it felt that these measures were the "lesser evil" compared with the proposals by Senator Kennedy. And, as Steinmo and Watts suggest, "congressional conservatives had difficulty arguing against a program whose explicit goal was to avoid government intervention by encouraging market competition"[21].

Signed into law in 1973, the National HMO Act provided government subsidies, in the form of grants, to private organizations meant to be competition to the currently existing health insurance companies. These new organizations became known as health maintenance organizations, or HMOs. The model of the HMO was the first significant emergence of "managed care". In an HMO plan, the subscriber has a primary care physician who has a contractual relationship with the HMO. If the subscriber needs to see a specialist for a specific condition, they first must get a referral from their physician and meet approval by the HMO. The HMOs and the medical service providers enter into contractual arrangements and negotiate prices for specific services. All medical procedures are subject to review by the HMO in an effort to reduce costs.

The National HMO Act of 1973 significantly fostered the growth of HMOs by not only offering grants to new HMOs, but the law also required employers who cover health insurance to offer an HMO plan as a choice of benefit. Hence, the number of people covered by this new type of entity grew dramatically after its introduction. Within a period of ten years, the number of Americans covered by an HMO grew from 6 million (1976) to 29.3 Million in 1987[22].

Since the introduction of the HMO, the payment system for medical practice has changed considerably. Traditional insurance companies concluded that they could no longer contain medical costs and compete with these new HMOs at the same time. During the 1980s, insurance companies all but abandoned the practice of indemnity. The principle behind indemnity was that physicians, acting individually on behalf of their patients, decided how most health care dollars were spent. Under the indemnity principle, physicians billed for their services, and third-party insurers usually reimbursed them without asking any questions, because the ultimate payers – employers – demanded no greater accounting[23]. However, as costs increased, those responsible for ultimately paying for medical costs of insured individuals (employers) and the payers (health insurance companies) set about searching for new ways to contain costs, which included the abandonment of the indemnity principle. Employers and their insurance companies now began taking a more active role on the decision of which doctor to go to, how much care one receives and the amount charged for each service – this has become known as "managed care".

Managed care in the 1990s and the Clinton health security initiative

By the end of the 1980s, the traditional health insurance plans that existed before 1975 were nearly nonexistent. Managed care plans emerged as the model to maintain low costs. By the 1990s, employers have changed from passive payers to aggressive purchasers and continued to exert more influence on payment rates, on where patients are cared for, and on the content of care[24].

These trends led reformers to once again attempt systematic reforms and, assert the need for a greater role of government in health care. By the early 1990s, public opinion expressed support for the reformers. For example, the public's support for universal coverage, in which the government guarantees everyone has health insurance, reached 82 percent in a 1991 poll. The 1992 election of President Bill Clinton, who ran with health care reform as a key policy issue, also showed renewed signs of momentum for health reform, and in September 1993 President Clinton announced his new health reform initiative, "Health Security" referencing the earlier efforts of Senator Ted Kennedy.

The principles of the Clinton health security care initiative echoed those of the past: universality, choice, quality, simplicity, and responsibility. The proposal mandated employer coverage and focused on the creation of regionally-based "Health Alliances" – government regulated purchasing pools of insurance plans that subscribers would buy into through their employer and largely based on the community-rating system (see above)[25]. The goal of the Clinton proposal was to mandate a change in how the insurance market is structured, but included no direct publicly sponsored program (with the exception of those already existing, such as Medicare and Medicaid). The role of government would be to enforce the new man-

[20] See: Quandago J., *Why the U.S. has no national health insurance: stakeholder mobilization against the welfare state*. „Journal of Health and Social Behavior" 2004; Vol. 45; Steinmo S., Watts J., *It's the Institutions, Stupid*. „Journal of Health Politics, Policy and Law" 1995; Vol. 20, No. 2, Summer.

[21] Steinmo S., Watts J., *It's the Institutions, Stupid*. „Journal of Health Politics, Policy and Law" 1995; Vol. 20, No. 2, Summer.

[22] Gruber L., Shadle M., & Polich C., *From Movement to Industry: the Growth of HMOs*. „Health Affairs" 1988;Vol. 7(3): 197–208, Summer.

[23] Igelhart J., *op. cit.*

[24] *Ibid*.

[25] Zelman W., *The Rationale Behind the Clinton Health Care Reform Plan*. „Health Affairs" 1994; Spring 13(1): 9–29.

dates, while state governments would regulate the health alliances. The rest of the cost control measures and regulation was left to the free market.

Despite initial public support and a clear avoidance of overt government intervention (this was the core of the strategy), the opposition to the Clinton health care reforms was fierce. The public relations effort to oppose the Clinton health care plan was unprecedented. One study found that an estimated $100 million was spent overall in 1993 and 1994 by 650 organizations to influence the health policy debate[26]. In advertising, groups opposed to the Clinton program outspent supporters by a 2-to-1 ratio[27]. The content of the advertising focused on the problems related to government bureaucracy, medical costs, and choice of doctors in the Clinton program.

The opposition's campaign successfully changed the attitudes of the public. By 1994, nearly two-thirds of Americans doubted the Clinton reforms. According to one poll, 63 percent felt that the Clinton plan had too much government involvement. Once again, the political barriers to passing health reform emerged. President Clinton and the Democrats were unable to achieve a clear consensus among the public and policy makers on major health care reform. By the end of 1994, the Clinton health care reform proposal officially succumbed to the political process with the midterm Congressional elections. Republicans decisively defeated the ruling Democrats and became the majority power in both chambers of the legislative branch, the House of Representatives and the Senate.

The failure of the Clinton health reforms to materialize, once again forced the market to become the default *modus operandi* for reform. As in the past, the changes that took place within the health insurance industry in the mid-1990s (after the failed reform efforts) saw an even greater-shift toward favoring free enterprise. Most notably in 1994, when the national Blue Cross Blue Shield Association changed its policies so that its licensees (the nonprofit Blue Cross and Blue Shield Plans) could convert to "for-profit" status and distribute earnings to those who exercise control over the company – the shareholders. As a result of this decision, the number of independent Blue plans fell sharply, from 67 in 1995 to 41 in 2003[28]. Similarly, HMO plans also shifted from originally being organized as nonprofit organizations to publicly-traded organizations accountable to the investors who owned them (the largest investors in managed-care companies became the health care providers themselves: hospitals and physicians)[29].

At first, the increased competition in the mid-1990s seemed to lower health care premiums and medical costs appeared to stabilize. However, by the start of the 21st century, trends in health insurance coverage of shifting to investor-owned publicly traded managed-care organizations with little government regulation, led to serious concerns over the future of the American health care financing and delivery system. Most importantly, medical costs began to rise again at an even quicker rate than previously seen and this trend dramatically affected the cost of health insurance. Since 2000, the cost of insurance premiums increased between 8 and 14 percent per year[30]. Between 1999 and 2009, health insurance premiums for families rose 131%, with the average cost of premiums for family coverage at $1,115 per month or $13,375 per year[31].

The mid-2000s witnessed new trends that prompted many renewed calls for a national health insurance program. These trends included:

- the shifting of Medical decision-making control away from the doctors to the insurance companies;
- the shifting of accountability to investors who owned shares in the private insurance company;
- the shifting of rising costs to the employers which, in turn, hurt the competitiveness of American industry as business bore higher costs of health care;
- the transfer of many costs from employers to employees in an effort to compensate for higher costs;
- an increase in the number of those without any insurance coverage to record levels;
- the imposition of restrictions on eligibility of coverage by insurance providers.

Considering these trends, it is unclear if the financing and delivery system can again curtail reform efforts and maintain the status quo, or if the concerns and indicators noted above will ultimately lead to successful reforms – the latter being the hope of Barack Obama and the Democratic Party in 2009.

2010: Characterizing the current debate on the U.S. health care system

History illustrates that the American health care system truly is an example of American "exceptionalism", as ideals of conservatism and the invisible hand of free-market have prevailed in financing coverage in the health care sector. The perspective provided by the historical, political, and institutional context forms the basic framework that is necessary to understand the current health care debate and reform efforts. As illustrated throughout this article, efforts on health care reform in the U.S. are characterized through a patchwork of fixes for specific problems in the system, while major reform efforts towards a greater governmental role met ultimate failure. Since the 1930s, Presidents and the Congress have not

[26] West D., et al., *Harry and Louise Go to Washington*. „Journal of Health Politics, Policy and Law" 1996; Vol. 21, No. 1, Spring.
[27] *Ibid.*
[28] Consumer Union, *op. cit.*
[29] Turnock B., *Managed Care and Public Health: Strange bedfellows?* In: Turnock B., *Public Health What it is and How it Works.* Jones and Bartlett, Sudbury, Massachusetts 2004: 122–128.
[30] Kaiser Family Foundation, *Health Care Costs – A Primer*, 2007. http://www.kff.org/insurance/upload/7670.pdf.
[31] The Kaiser Family Foundation & Health Research and Education Trust, *2009 Annual Survey: Employer Health Benefits*, 2009. http://ehbs.kff.org/pdf/2009/7936.pdf.

been able to introduce and pass any comprehensive reforms toward building a single-payer health insurance system. Any reform efforts that did make it into legislation were based on political compromise and heavily influenced by special interests and lobbying efforts.

Many political and health scholars have noted that America's "exceptionalism" hinders reform and favors the status quo. For example, David Wilsford noted that the "fragmented, diffuse institutions provide structures that strongly favor the status quo."[32] Steinmo and Watts agreed with Wilsford's assertion, stating "America did not pass comprehensive national health care reform in 1994 for the same reason it could not pass it in 1948, 1965, 1974, and 1978... because American political institutions are structurally biased against this kind of comprehensive reform"[33]. Odin Anderson was much more pessimistic in his assessment of the lack of reform. In 1987 he wrote, "There will never be universal, compulsory national health insurance in the United States on the pattern of European countries and Canada. [The U.S.] appears incapable of supporting one"[34].

Many factors can be used to explain health reform failure for each specific point in the past. Yet, history undoubtedly shows that, time and again, for nearly 100 years, the private medical interests (insurance and doctors) have managed to stop any development towards a compulsory national health insurance system. The status quo has predominantly prevailed against any comprehensive health reform efforts. By all indication, however, 2010 will be different. Proposed reforms have already passed many key barriers that halted reform in the past, and the socio-economic indicators of the American health care system point to a greater need for reform than any previous point in time.

Key indicators of the American health care system today

Internationally, the United States has not fared exceptionally well in comparison to other developed nations, as Canada, Western European countries, Australia and New Zealand. In 2000, the World Health Organization ranked the American health system 37th in the world[35]. The 2009 OECD report highlights some crucial trends in the American health care sector, most notably that the U.S. spends 16% of its GDP on health care, higher than any other country (average OECD is 8.9%) and 45% of health care funding is from the public sector, with the average OECD country being 73%[36]. Public health indicators also point to some concerns in the American health care system, for example nearly 30% of the adult population in the United States is considered obese[37]. In 2006, the U.S. had 36 diabetes-related amputations per 100,000 people (compared with an OECD average of 15 per 100,000). Mark Parson of the OECD, in a statement to the U.S. Senate wrote, that "the United States does not do well in preventing costly hospital admissions for chronic conditions, such as asthma or complications from diabetes, which should normally be managed through proper primary care"[38].

Another key indicator of the American health system is the imbalance of access to quality of care. Many scholars point to the unfair balance of the private health insurance system as a driving factor for these poor indicators. It is important to note, that since health insurance in the United States is voluntary, and through the employer, a duality in the social-structure has emerged: those who have insurance and those who do not. As medical costs continue to rise and insurance companies seek to maintain a certain level of profit, the number of Americans who do not have health insurance has also grown considerably since the mid-1990s. In 2008, the number of Americans with no health insurance stood at 46.3 million, or 15.4% of the population[39]. Further to this, some studies point to the lack of adequate coverage as a key indicator of a broken system. One study found that an estimated 25 million adults are underinsured in the United States, meaning they technically have health insurance coverage, but they still have difficulty accessing care and specific treatments[40].

As I note throughout the article, financing the American health care system has evolved considerably over the last 70 years. Today the system is primarily a managed-care system, by which employers who cover their employees purchase a plan that manages the care of its subscribers. The plans are oftentimes profit-driven and take measures to keep costs as low as possible. Employees, who do have insurance through their employer, usually share a relatively high portion of the cost. Since the 1970s, employees with health insurance began sharing more and more of the costs of insurance with the employers. These cost-sharing values are set by the employer and the insurance plan to keep subscribers from "overusing" health care. This takes the form of co-payments (a payment that must be made at time of service) and deductibles. A deductible is the amount a subscriber is responsible per year for his or her own health care costs. For example, if an employee has a health insurance

[32] Wilsford D., *Path Dependency, or Why History Makes it Difficult but not Impossible to Reform Health Care Systems in a big way*. In: Watson J. and Ovseiko P. (2005), *Health Care Systems: Understanding health care politics.* Routlege: New York, USA 2005: 355–383.

[33] Steinmo S., Watts J., *op. cit.*

[34] Anderson O., *Health Services in the United States: A growth enterprise since 1875.* Health Administration Press, Ann Arbor, MI: 280.

[35] The World Health Organization, *The World Health Report, Health Systems: Improving performance*, 2000. http://www.who.int/whr/2000/en/.

[36] OECD Report, *op. cit.*

[37] See U.S. Centers for Disease Control and Prevention. http://www.cdc.gov/obesity/data/trends.html.

[38] Parson M., *Disparities in health expenditure across OECD countries: Why does the United States spend so much more than other countries?* Written Statement to Senate Special Committee on Aging – 30th September 2009. http://www.oecdwash.org/PDFILES/Pearson_Testimony_30Sept2009.pdf.

[39] U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2008.*Washington, DC 2009. http://www.census.gov/prod/2009pubs/p60-236.pdf.

[40] Schoen C., et al., *How Many Underinsured? Trends Among U.S. Adults 2003–2007*. „Health Affairs. Web Exclusive" 2008; 10 June.

plan with a $500 deductible, the employee is responsible for the first $500 of medical costs in a defined year, once those are paid, the health insurance company will cover the remaining costs that year (the higher the deductible, the cheaper the plan). As a last resort, employers that cannot or can not keep up with the rising costs of covering their employees have one last option. As Hacker wrote in 1996, "the simplest solution, of course, [is] to stop offering insurance altogether, which many new entrants and small firms did, especially in the growing service and retail sectors of the economy"[41].

Not having health insurance, or adequate insurance, has a tremendous impact on the overall health of the society and some recent studies illustrate dire consequences. One study found that in 2007, 62.1% of all personal bankruptcies in the United States had a medical cause. It also noted that, most medical debtors were well educated and middle class; three quarters had health insurance and the share of bankruptcies attributable to medical problems rose by 50% between 2001 and 2007[42]. Another study found that over 35,000 persons between 18 to 64 die annually as a result of lack of health insurance[43]. Similarly, a study by the Urban Institute found that 137,000 people died between 2000 and 2006 because they lacked health insurance[44]. Finally, the Commonwealth Fund concluded: "Absent significant reforms, current projections estimate that national per-person spending on health insurance premiums will increase by 94 percent from 2009 to 2020, increasing an average of 5.7 percent annually".

The Obama health reform plan: parallels and lessons from history

Memory in politics is oftentimes quite short-term. In the current debate, many politicians now draw the parallel between President Obama's efforts and the failed efforts of the Clinton proposals of the 1990s. However, one should note that the parallels between earlier Presidents, such as Harry Truman, and President Obama are just as striking. During Truman's national health insurance efforts, the opposition was well funded. In 1948, Truman had a Democratic Congress, however many southern Democrats (or Dixiecrats as they were known then) voted conservatively, often with Republicans on social issues. In 2010, President Obama also enjoys a Democratically-controlled Congress, however, several conservative Democrats (or "blue-dogs" as they are often referred to today) have threatened to vote against health reform and universal coverage if it is too "liberal".

The surface similarities between the Truman and Obama situations should not obscure the fundamental differences in politics and health care between then and now. Despite the parallels, the American health care system today is still very different than the relatively new system of Truman's time or even Kennedy's time. History shows us that physicians and the medical profession in the United States, unlike any other country, wanted not only to control the methods of treatment, but also the methods and sources of payments, in other words, the entire health care delivery system. This was the case, until the mid-1990s. The rise of managed care and the shift from nonprofit to profit-oriented health insurance companies, in effect, took away that control. The physicians now find themselves in the position of supporting President Obama's health care reform principles, as evidenced by the AMA's April 13, 2009 letter of support[45].

Opposition, however, still exists and is as strong, if not stronger, as it has been in the last 100 years. A fairly large, well-organized opposition to President Obama's health care proposal emerged during the summer of 2009. Most notably has been the conservative activist group, the "Tea Party Patriots" who organized anti-health reform protests throughout the summer of 2009. Other conservative opposition groups include Conservatives for Patients' Rights, Americans for Prosperity, and FreedomWorks, which distributes a "Health Care Action Kit" for protesters. Props include an "ObamaCare Insurance Card" with the slogan: "A collective plan administered by the politicians and bureaucrats of the U.S. government"[46]. The arguments claimed by the opposition are very similar to those made in the past 50 years, including fears of: "socialized medicine", a government take-over of health care, rationing of care, and long lines at the clinics to receive treatment.

Key characteristics of Obama's health care reforms

Similar to President Clinton, President Obama addressed the Congress in order to outline his principles for health reform. The September 10, 2009 address to Congress promoted his vision of health care reform, emphasizing the need to make it illegal for insurers to drop sick people or deny them coverage for pre-existing conditions, and ensure universal coverage, by mandating that every American would be required to carry health coverage.

[41] Hacker J., *National Health Care Reform: An Idea Whose Time Came and Went*. „Journal of Health Politics, Policy and Law" 1996; Vol. 21, No. 4, Winter.

[42] Himmelstein D., et al., *Medical Bankruptcy in the United States, 2007: Results of a national study*. „The American Journal of Medicine" 2009; Vol. 122(8).

[43] Wilper A., et al., *Health Insurance and Mortality in U.S. Adults*. „American Journal of Public Health" 2009; Vol. 29 (12), Dec.

[44] Dorn S., *Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality*. Urban Institute. January 2008. http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf.

[45] See: American Medical Association letter to the President. 13 April 2009. http://www.ama-assn.org/ama1/pub/upload/mm/399/hsr-principles-letter.pdf.

[46] Rucker P. and Eggen D., *Rowdy Protests at Health Forums*. „The Seattle Times" 2009; Aug. 6. http://seattletimes.nwsource.com/html/health/2009607024_townhall06.html.

Obama charged the Democratically-controlled Congress to develop legislation on health care reform based on his vision and key principles, including[47]:

- Reduce long-term growth of health care costs for businesses and government.
- Protect families from bankruptcy or debt because of health care costs.
- Guarantee choice of doctors and health plans.
- Invest in prevention and wellness.
- Improve patient safety and quality of care.
- Assure affordable, quality health coverage for all Americans.
- Maintain coverage when you change or lose your job.
- End barriers to coverage for people with pre-existing medical conditions.

Following President Obama's call for reform, both chambers of the U.S. Congress, the House of Representatives and the Senate, developed separate legislative proposals based on long negotiations, compromise, and a need to respond to public skepticism. The proposals primarily focused on cost controls and fostering competition in the private insurance market (a familiar theme). By the end of 2009, both the Senate and the House of Representatives passed a bill to reform health care; however both bills were very different, and in order for them to become a law, one bill must be agreed upon between both chambers.

Despite the differences between the two bills, common reforms do exist and would most likely make it into the final law. These include[48]:

1. **Create Health Insurance Exchanges**: the purpose of the health insurance exchange is to create a marketplace for health insurance plans (similar to the Clinton health alliance), ensure competition, lower costs and provide individuals the freedom to choose the right health insurance plan for them. Participation in the exchanges will be available to individuals without insurance or those who are unhappy with their current coverage, as well as small businesses that cannot afford to provide coverage directly for their employees through traditional plans.
2. **Prohibit insurance coverage based on health status or pre-existing conditions**: It will be illegal for health insurance companies to deny coverage due to an existing condition (a common practice) or drop coverage as a result of a major illness.
3. **Mandate compulsory health insurance**: Individuals will be required to obtain health insurance coverage or pay a penalty fee. Individuals may apply for a hardship waiver if coverage is unaffordable.
4. **Focus on prevention and wellness**: Insurance companies will be required to cover all costs of prevention and wellness benefits and exempt these benefits from deductibles and other cost-sharing requirements in insurance coverage. The law will also create a grant program for small and medium size companies to offer wellness programs to their employees.
5. **Provide funding for the public health infrastructure**: The law will provide new funding for state and local public health departments to build their capacity to address public health epidemics and to be prepared for public health emergencies and pandemics.
6. **No new government-run insurance program**: The new law would not create any new government-run program, despite considerable debate for such a program (labeled the "public-option"). Many advocates of a single-payer program thought that this time around would be the time to include elements of a national health insurance program in the reforms. However, it is clear from the legislative proposals that no such program is likely to be created.

Pass or fail? The fate of the 2010 health care reform

One political commentator, Jacob Wiesberg, recently asserted that these reforms would be more than symbolic. He wrote, "For the federal government to take more responsibility for health coverage will be a transformation of the American social contract and the single biggest change in government's role since the New Deal"[49]. On January 9, 2010, when referring to the proposed health reforms in Congress, President Obama stated: "All told, these changes represent the most sweeping reforms and toughest restrictions on insurance companies that this country has ever known"[50]. Historically speaking, if these proposals would pass, they indeed would be the most substantial changes to the U.S. health care system since the introduction of Medicare and Medicaid in the 1960s. However, the political environment remains to be the greatest barrier to reform. For most Americans, the focus of health care reform has remained largely on the political process, often expressed through demonstrations of anger and emotion. During the Congressional recess in August of 2009, town-hall meetings held across the country were filled with angry protesters against the health care reforms. These protests significantly eroded public support President Obama and his health care reforms. As late as January 2010, public support for health care reform efforts by President Obama has dropped, with 58 percent of the public opposing the bills previously passed by the House and Senate, and only 38 percent supporting that legislation[51]. With the death of Senator Ted Kennedy in August 2009 (a major proponent for health reform) and the loss of his seat to a Republican during a special

[47] The White House, *Health Care*. http://www.whitehouse.gov/Issues/health-Care.

[48] For more information see: *Senate Democrats Lead Historic Passage Of The Patient Protection And Affordable Care Act*. http://democrats.senate.gov/newsroom/record.cfm?id=321145& and *H.R. 3962, the "The Affordable Health Care for America Act*. http://democrats.energycommerce.house.gov/index.php?q=bill/hr-3962-the-the-affordable-health-care-for-america-act.

[49] Weisberg J., *Obama's Brilliant First Year*. *Slate.com*. Posted Nov. 28, 2009. http://www.slate.com/id/2236708/.

[50] *Weekly Address: President Obama Outlines Benefits of Health Reform to Take Effect This Year*: Remarks of President Barack Obama As Prepared for Delivery. 9 January 2010. http://www.whitehouse.gov/the-press-office/weekly-address-president-obama-outlines-benefits-health-reform-take-effect-year.

[51] CNN.Com (2010, January 26), *Poll: Half say start anew on health care bill*. CNN. http://www.cnn.com/2010/POLITICS/01/26/poll.health.care/ .

election in January 2010, prospects for reform are still questionable. Many factors will lead to the passage or failure of the health care bill, however, one thing is certain: history has shown that any move towards a stronger governmental role in health care is incredibly difficult.

Hacker and Skacpol rightly note that throughout history, failure to pass major reform on health care and in the aftermath of political defeats, the private market emerged to rapidly transform patterns of health care financing and delivery[52]. If the Obama Administration and Democrats in Congress fail to pass any sort of health care reform legislation how would the private market respond? This is a key question to ask, since very few options are viable. Would it be possible to see a reemergence of nonprofit health care plans that are more affordable? Will more states address the issue of universal health insurance coverage at the state-level (such as Massachusetts, Hawaii and Vermont)? Will private insurance become more "value-based" (aimed to reduce patient co-payments for services that provide important clinical benefit, relative to costs)?[53] Could private plans begin to move beyond managed-care to direct provision of services, from clinical and hospital care to provision of prescription drugs and employment of their own medical workforce? These are difficult scenarios to envision, still, absent any sort of mandated change, the health services researcher and health economist could speculate endlessly.

Hence, the question that still remains for 2010: Is Obama likely to repeat history or will he actually be successful in passing reforms aimed at significantly altering the health care system? It is most likely that the answer to this question is that a good number of these reforms will pass, despite the strong opposition. Many of the major hurdles have already been overcome in the political process. Both chambers have passed bills with similar proposals, a certain level of public support remains for health care reform, and the President has demonstrated a commitment to compromise in order to achieve some form of health care reform.

To illustrate the endurance of the reform efforts, on February 22, 2010, President Obama and the White House released a new proposal outlining specific reforms for health care. This new proposal is largely based on the existing Senate bill and contains the same reforms outlined above in this article. The goal of the proposal was to garner further support for the reform efforts and encourage Congress to pass the reforms into law[54]. Further to this, on February 25, 2010, the President hosted both Democrats and Republicans for a seven-hour long, televised summit on health care reform. The summit was meant to allow both parties to discuss their ideas for health care reform in the framework of the President's proposal and discuss measures to finally pass health care reform in Congress. Following the health care summit, President Obama indicated his desire to complete the health care reform process when he said, "It is time for us to act. So let's get this done"[55].

It is likely that President Obama and the Democrats will pass several key reforms. Their effect, however, will be visible years down the road as most of the reforms will be phased in between now and 2014. If successful, they will help secure better access to health care in the United States and bring down costs of insurance by introducing new changes to this very complex health system. The political consequences, however, will be visible much sooner. This year is an election year for Congress. The results will be a strong indicator of whether the American people agree with these reforms and how policy makers will address future efforts to alter the health care system.

Abstract:

In 2009, following the election of Barack Obama to the Presidency of the United States, the American public entered into a fierce debate on how to reform its health care system. The intense debate on health care reform, however, is not a new phenomenon in American political life. Debate over health care has cycled its way into the American political discourse every twenty-years or so. History suggests that forceful opposition has prevailed against most major efforts to alter the health system in the United States. Yet, once again the Democratically-controlled Congress and Presidency in the United States aspire to break this cycle of history. With both houses in Congress passing a bill with significant reforms, it seems that this time may be different. While it is very likely some reforms will pass in 2010, no law has been signed yet[56]. In the end, only time will dictate the outcome of this round of health reform debates.

Through a thorough literature review, this article provides the Polish reader a sense of health care reform efforts in the U.S. from the historical perspective and discusses the current proposed reforms. Particular attention is paid to the evolution of the American health insurance system, failed efforts of past health reform initiatives, their contrast with today's efforts, and current health and economic indicators that could lead to reform in 2010.

Streszczenie:

Reforma zdrowotna w Stanach Zjednoczonych: analiza historyczna dyskursu

Słowa kluczowe: reforma zdrowotna, opieka zdrowotna w USA, finansowanie ochrony zdrowia

W 2009 r., po wyborze Baracka Obamy na prezydenta Stanów Zjednoczonych, społeczeństwo amerykańskie rozpoczęło merytoryczną dyskusję nad reformą systemu opieki zdrowotnej. Dyskusja ta, znana również – dzięki przekazom medialnym – polskiemu Czytelnikowi, nie jest wydarzeniem nowym ani związanym z bieżącą sytuacją. Analiza historyczna amerykańskiego dyskursu publicznego w wieku XX wskazuje na pewną tendencję: każdorazowe zwycięstwo przeciwników reformy niezależnie od merytorycznych przesłanek podejmowanych reform. W tym kontekście bezprecedensowa zdaje się aspiracja 111 Kongresu Ameryki, kontrolowanego przez polityków Partii Demokratycznej oraz przy współpracy z pochodzącym z tej partii Prezydentem, do przełamania dotychczasowego

[52] Hacker J., Skocpol T., *The New Politics of U.S. Health Policy*. „Journal of Health Politics Policy and Law" 1997; Vol. 22, No. 2, April.

[53] More information can be found here: http://www.sph.umich.edu/vbidcenter/index.htm.

[54] The White House (22 Feb 2010), *Putting Americans In Control of Their Health Care*. http://www.whitehouse.gov/health-care-meeting/proposal.

[55] The White House. Office of the Press Secretary (Feb 27 2010), *Weekly Address: President Obama Says Washington Must Use This Opportunity to Enact Health Reform*. http://www.whitehouse.gov/the-press-office/weekly-address-president-obama-says-washington-must-use-opportunity-enact-health-re.

[56] As of completion of this article in February 2010, no reforms were passed.

cyklu historii. Zdawać się może, że próba ta powiodła się, czego odzwierciedleniem są inicjatywy ustawodawcze obu Izb Kongresu. Chociaż z dużym prawdopodobieństwem można przypuszczać, iż amerykański system opieki zdrowotnej zostanie w końcu poddany reformie, to jednak na dzień dzisiejszy (luty 2010 – data oddania niniejszego artykułu do druku) brakuje przyjętej przez obie Izby Kongresu oraz podpisanej przez Prezydenta ustawy regulującej te kwestie. Oznacza to, ze poznanie prawdziwego wyniku tego etapu dyskusji nad systemem opieki zdrowotnej w USA to jedynie kwestia czasu. Poprzez pogłębiony przegląd literatury przedmiotu Autor artykułu przedstawia polskiemu Czytelnikowi argumentacje poprzednich i współczesnych przeciwników reform. Dokładnej analizie poddana jest ewolucja systemu ubezpieczeń zdrowotnych, przeszłych niepowodzeń reform oraz ich porównanie z podejmowanymi obecnie działaniami na rzecz zmiany systemu. Ponadto Autor analizuje współczesne wskaźniki zdrowotne i makroekonomiczne jako czynniki sprzyjające przełamaniu historycznego oporu wobec reformy.

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